MEDICAL BOARD OF CALIFORNIA
LICENSING OPERATIONS
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382
www.caldocinfo.ca.gov

Fictitious Name Permit
Notification of Partnership Change

Fictitious Name: _____ **FNP #:** _____

Current Physical Practice Address: (No PO Box) _____

_____ **Phone #:** _____

_____

Business Type: PARTNERSHIP

If you wish to *add or delete partners*, please provide the following information in the table below. Signatures are required to associate or disassociate partners, and this form also must include a signature at the bottom signed by a current partner.

Doctor's Name (print or type)	License #	Association Date	Disassociation Date	Signature

I certify, under penalty of perjury, and the laws of the State of California, that the information provided in this "Notification of Partnership Change" form, including any supporting documents, are true and correct. I further certify that I am a partner authorized to act on behalf of the above-stated entity, and the information contained herein is true and correct.

_____ _____ _____ _____

Print or Type Name ***Partner's Signature*** ***Date*** ***License #***